Chapter 10

Model of Care

The South Country Health Alliance Model of Care is our plan to address the unique needs of each member in AbilityCare (Special Needs Basic Care (SNBC)), a highly integrated Medicare Advantage Special Needs Plan, and SeniorCare Complete (Minnesota Senior Health Options (MSHO)), a fully integrated Medicare Advantage Special Needs Plan. Both of these plans are for individuals eligible for both Medicare and Medicaid and are HMO D-SNP plans.

About Our AbilityCare Members

Medicare beneficiaries are eligible to voluntarily enroll in AbilityCare with South Country if they are:

- Between the age eighteen (18) through age sixty-four (64);
- Eligible for Medicaid;
- Eligible for Medicare Part A and Part B;
- Reside within South Country's Service area (Brown, Dodge, Goodhue, Sibley, Steele, Wabasha, and Waseca counties); and
- Certified disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT) or have a developmental disability (DD) or related conditions for the purpose of the DD Waiver as determined by the local agency.

The average age of our AbilityCare members is 50. Around 80% of our members enrolled in AbilityCare are between the ages of 40 - 64. Approximately 89% of AbilityCare members reside in the community. On average members have:

- Four (4) chronic conditions, and
- Eight (8) primary care visits within a given year.

Sixteen percent (16%) of our members are hospitalized within a given year. The top five (5) reported chronic conditions are anxiety disorders, depression, hypertension, hyperlipidemia and fibromyalgia, chronic pain and fatigue based off the Centers for Medicare & Medicaid Services Chronic Conditions Data Warehouse (CCW) and ICD-10 codes identified in the CCW Condition Algorithms.

About Our SeniorCare Complete Members

Medicare beneficiaries are eligible to voluntarily enroll in SeniorCare Complete with South Country if they are:

- Sixty-five (65) years of age or older; or
- Turning sixty-five (65) years of age within the month they are requesting SeniorCare Complete enrollment; and are
- Eligible for Medicaid and Medicare Parts A and B; and
- Reside within South Country's service area (Brown, Dodge, Goodhue, Sibley, Steele, Wabasha, and Waseca counties).

Our SeniorCare Complete population is older when compared to the national averages based on the 2021 Cohort 24 Baseline Demographics for Health Outcomes Survey (HOS). South

Country has 41% of our membership ages 80+ compared to the national average of 24% being 80+. There are more females enrolled in SeniorCare Complete compared to males, with females making up around 70% of the membership. Approximately 77% of SeniorCare Complete members reside in the community. On average members have:

- Five (5) chronic conditions, and
- Five (5) primary care visits within a given year.
- Twenty (20) percent of the members are hospitalized within a given year.

The top five (5) reported chronic conditions are hypertension, hyperlipidemia, chronic kidney disease, depression and arthritis based off the Centers for Medicare & Medicaid Services Chronic Conditions Data Warehouse (CCW) and ICD-10 codes identified in the CCW Condition Algorithms.

Care Coordination

Care coordinators live and work in the communities of our members and are experts in identifying and working with local providers and resources. This relationship significantly improves the member experience, streamlining the process of meeting the needs of members while emphasizing preventive care and reducing the unnecessary use of health care resources.

AbilityCare and SeniorCare Complete members are assigned a county-based care coordinator. Some AbilityCare members are assigned an internal care coordinator at South Country. Care coordinator tasks include, but are not limited to:

- Conducting initial, annual, and periodic health assessments using an approved tool to learn about the member's support and service needs.
    - It is expected that the in-person health risk assessment will be completed within thirty (30) days of enrollment and no more than 365 days after the previous health risk assessment for those who are continuously enrolled. The health risk assessment tool is a guide to facilitate discussion with the member and the member's interdisciplinary care team (their level of involvement is by member choice) about their strengths, goals, wishes, needs, health concerns, and choices about their life, housing, and the services and supports needed to remain in and integrate into the community where they reside.
- Facilitating access to specialists and therapies.
- Triaging care needs and wants with South Country staff, providers, their primary care provider, and other participants on the interdisciplinary care team as needed.
- Advocating, informing, and educating members, and creating a path to access South Country's services and benefits.
- Educating members on self-management techniques including good health care practices and behaviors, which prevent putting the member's health at risk and working to keep members engaged in their own care.
- Facilitating the development, implementation, monitoring, and updating of the individualized care plan built from information obtained in the health risk assessment, and the distribution of the individualized care plan for each member.
    - It is the expectation that the care coordinator utilizes that information learned through the health risk assessment process and during the health risk assessment visit/discussion to develop with the member an individualized care plan that is person-centered and driven by what the member and/or authorized representative has voiced as goals, areas they want to work on, and what they

want and need from formal and/or informal services and supports. It is expected that the care coordinator will include the member in the development of the individualized care plan and will finish and send it to the member to review and sign (if in agreement) within thirty (30) days of the health risk assessment. It is expected that the care coordinator will make updates to the individualized care plan in a timely manner and send it out for review by the member any time there is a significant change to the member's health status or a change to the member's chosen services or provider.

- Communicating effectively and sharing the member's individualized care plan (e.g., goals, services, and wishes) with the member and the member's chosen interdisciplinary care team.
- For SeniorCare Complete members, arranging and/or coordinating the provisions of managed long-term services and supports identified in the individualized care plan, including knowledgeable and skilled specialty services and prevention, early intervention, social supports, and all medically necessary services.
- Retrieving consultation and diagnostic reports from contracted specialists.
- Facilitating translation services for members through the South Country's contracted telephonic interpreter line or accessing contracted in-person interpreters as needed.
- Assisting the member or member's authorized representative, if applicable, to navigate the health care system, maximize informed choice of services and provides, and preserve member control over services and supports.
- Facilitating and coordinating all transitions of care, as needed, for each member including ensuring that the member has the right service, at the right time and from the correct provider, and that member choice is reflected regarding all changes in care setting.
- Assisting members in selecting a primary care clinic or practitioner.
- Following up with members on utilization management activities such as hospitalization or emergency department use.
- Assisting with scheduling appointments for primary and preventive medical and dental care and follow-up services for each member.
- Assisting members, as needed, with transportation services to ensure they have timely and appropriate travel to and from appointments.

Interdisciplinary Care Team (ICT)

The interdisciplinary care team for each member case acts as an important part of our Model of Care. The ICT is a collaborative group that may consist of South Country staff, care coordinators, the community care connector, authorized representatives, and providers. Some of the goals of the ICT include the following:

- Sharing clinical information to ensure members receive appropriate and timely care.
- Sharing completed member care plans directly with providers to improve understanding of member preferences.
- Monitoring transitions in care (e.g., emergency room visits and hospitalizations) to improve discharge planning, decrease length of stays, decrease readmissions, and improve overall care.

At a minimum, the care coordinator communicates annually with the member's primary care provider identified by the member.

Care Transition Protocols

Transition of care services are provided by the member's care coordinator when they move from one care setting to another due to a change in health status. Examples of care transition settings include: moving to/from home, acute care, skilled nursing facility, custodial nursing facility, regional treatment center, outpatient surgery, or a rehabilitation facility. Any movement between settings of care is a separate transition including the member's transition back to their usual care setting. Proactive care coordination is provided to prevent transitions including unnecessary emergency room visits and hospitalizations and coordinating services for members at high risk of having a transition (e.g., falls, lack of preventive care, or poor chronic disease management).

The care coordinator is responsible for completing outreach to the most appropriate individual to assist the member through the transition. This could include but is not limited to: the member and/or the member's authorized representative, nursing home or residential service staff within one (1) business day of notification from South Country. South Country requires hospitals to notify South Country of an admission within one (1) business day. The protocol is South Country notifies the community care connector (as South Country's liaison) located in the member's county of residence about a member hospitalization (admission and/or discharge). South Country sends this communication to the community care connector through TruCare, our electronic care coordination documentation system. The community care connector then forwards the transition information to the care coordinator working with that member.

The care coordinator is responsible for managing the member's transition as the member moves from care setting to care setting. As part of the care transition process, the care coordinator must communicate with the member's primary care provider (for example, physician) to ensure that the primary care provider is aware of the member's hospitalization and to discuss possible long-term changes in health status and potential needed services or supports upon discharge including a possible change in medications.

The care coordinator must document all the tasks involved in the member's care transition process on the transitions of care (TOC) log. The log helps guide the care coordinator to ensure that all care transition tasks are completed as directed by South Country and that care coordinators work directly with all applicable providers involved in the transition. The log is designed to ensure that when followed the member has optimal receipt of continuity of care and support throughout changes in care settings.

Provider Network

South Country has a comprehensive and geographically dispersed provider network created to meet the health and well-being needs of our members throughout our seven (7) participating counties. Our provider network consists of local community-based providers and state-wide health systems that include primary care, hospitals, behavioral health (including mental health and chemical dependency), specialty care, home care agencies, medical equipment and supplies, pharmacies, dentists, and non-emergency transportation.

Measurable Goals & Health Outcomes

Goal 1

Improve the ease of navigating the clinical and social system for the member and assure that the member has access to the right services at the right time from the right provider and that is affordable.

- Desired Outcome: To provide integrated care coordination and promote the accessibility of services, including preventive health services, and provide comprehensive coordination of all services to meet the needs and wants of members across the continuum: social services, public health, medical and other community services.
- Process: A health risk assessment will be completed, and an individual care plan will be developed collaboratively by the care coordinator and the member, if the member is willing, with the input from the members of the interdisciplinary care team.
- Measure 1: The percentage of members who have a completed initial health risk assessment within thirty (30) days of enrollment (for SeniorCare Complete) or within sixty (60) days of enrollment (for AbilityCare).
- Measure 2: The percentage of members who have an annual health risk assessment completed no more than 365 days from the previous health risk assessment.
- Measure 3: The percentage of members who have developed, with the assistance of their care coordinator, an individual care plan (ICP) within 30 days of the completed health assessment, which identifies their ICT.

Goal 2

Ensure that members receive care and services from a system that is seamless for members across health care settings, providers, and health and social services.

- Desired Outcome: Members will experience seamless transitions of care across health care settings, providers, and health/social services.
- Process: Care coordinators will be notified regarding a health care event (e.g., hospitalization or nursing facility placement) for follow up with the member or most appropriate individual to assist with the member through the transition.
- Measure 1: The percentage of members (or the most appropriate individual to assist the member) contacted within one (1) business day for follow up by a care coordinator for a health care event when notified fourteen (14) days or less after the event.
- Measure 2: The percentage of members who discharge from a hospital and have a completed medication reconciliation within 30 days of discharge following Healthcare Effectiveness Data and Information Set (HEDIS) specifications for medication reconciliation post discharge.

Goal 3

Ensure that members receive preventive or ambulatory services annually and to help control diabetes and hypertension.

- Desired Outcome: Service accessibility and utilization for preventive health services and services to manage chronic conditions.
- Measure 1: The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.
- Measure 2: The percentage of members age 75 and under with diabetes (Types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c <9.0%.
- Measure 3: The percentage of members age 85 and under who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Evaluation

To make sure that our Model of Care is a successful framework for the delivery of our integrated Medicare and Medical Assistance products, our model is evaluated through a plan-do-act-check cycle. Results are documented and preserved as evidence of the effectiveness of the Model of Care and reviewed for opportunities to improve processes and strategies where needed.

Questions

If you have further questions, please contact South Country at 1-507-444-7770 or FAX 1-866-722-7770.